SUPREME COURT, U.S.
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No. 92-315

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1992

CESAR A. PERALES, as Commissioner of Social Services of the State of New York,

Petitioner,

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, SIDNEY FINKEL, JOHN A. BLESKI and LOUIS W. SULLIVAN, as Secretary of the United States Department of Health and Human Services,

Respondents.

BRIEF OF RESPONDENTS NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, FINKEL AND BLESKI IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

Are states required to pay Medicare coinsurance and deductible amounts in full on behalf of persons dually eligible for Medicare and Medicaid benefits and other "qualified medicare beneficiaries"?

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Respondents New York City Health and Hospitals Corporation, Medical Society of the State of New York,[1] Sidney Finkel and John A. Bleski oppose the Commissioner of Social

1. There are no parent or subsidiary companies of New York City Health and Hospitals Corporation or Medical Society of the State of New York to be listed pursuant to Supreme Court Rule 29.1.

Services of the State of New York's Petition for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

STATEMENT OF THE CASE

This case involves the elimination by New York State, effective January 1, 1987, of the statutory rights of health care providers to receive certain payments for services rendered to persons dually eligible for Medicare and Medicaid benefits ("dual eligibles" or "crossovers") and other "qualified medicare beneficiaries" ("QMBs"), a category of Medicare beneficiaries with income and resources below federal poverty levels.

The payments here at issue are Medicare "cost-sharing" amounts: the annual deductible and 20% coinsurance portion of the Medicare-approved reasonable costs or charges for which the Medicare-eligible patient remains personally liable. Historically, the New York Medicaid Program reimbursed providers for such cost-sharing amounts on behalf of dual eligibles. Effective January 1, 1987, New York State amended its Regulations so as to (i) eliminate or drastically reduce all such Medicaid reimbursement for the Medicare cost-sharing amounts, and (ii) prohibit providers from seeking to recover such amounts from dual eligibles. These Regulations were later amended to extend the same payment limitation to other QMBs.

The Court of Appeals correctly held that federal law entitles providers to receive full payment of the cost-sharing amounts attributable to dual eligibles and other QMBs.

The Medicare Program

In 1965 Congress established the Medicare Program as Title XVIII of the Social Security Act, 42 U.S.C. §§1395-1395ccc. Medicare is a purely federal program which provides reimbursement for medical care to the aged and certain disabled persons.

There are two components to the Medicare Program. Part A (which is not involved in this case) provides hospital insurance benefits and is financed by Social Security payroll contributions. 42 U.S.C. §§1395c-1395i-4. Part B is a voluntary supplementary

program for Medicare-eligibles who choose to enroll, which pays for certain physician services, hospital outpatient services, and other health services generally not covered under Part A. 42 U.S.C. §§1395j-1395w-4(j). The beneficiary is required to pay an enrollment premium and an annual deductible for services covered under Part B. Above this deductible amount, Medicare pays 80% of the "reasonable costs" in the case of services provided by a hospital, and 80% of the "reasonable charges" for physician services, as those costs and charges are calculated and established pursuant to the Medicare Act and Regulations. The beneficiary is responsible for the remaining 20% coinsurance amount.

Providers are entitled to receive *full* reasonable costs and charges for *all* services provided to *all* Medicare beneficiaries. 42 U.S.C. §1395*l*; 42 C.F.R. §§405.501, 410.150, 410.152. This entitlement is fulfilled through the 80% Medicare payment and the beneficiaries' payment of the "cost-sharing" amounts – the deductible and 20% coinsurance.

The Medicaid Program

Concurrently with the enactment of Medicare in 1965, Congress established the Medicaid program as Title XIX of the Social Security Act, 42 U.S.C. §§1396, *et seq.*, to provide federal financial assistance to states that choose to reimburse the costs of medical care for needy persons. To qualify for federal matching funds, states participating in the Medicaid program must have a state plan that has been approved by the Secretary of Health and Human Services (the "Secretary") as conforming with federal requirements. 42 U.S.C. §§1396a(a), 1396a(b).

Payment rates for services provided under the Medicaid program are established by the states and are generally not based on the "reasonable cost" or "reasonable charge" standards that govern payment under Medicare. New York State has established Medicaid reimbursement rates that are (i) in all cases lower than the "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services and (ii) in almost all cases lower than the Medicare payment of 80% of such "reasonable cost" or "reasonable charges."

QMBs and Dually Eligible Individuals

In order to assure full and equal access to health care services and provide for full payment of Medicare reasonable costs and charges for *all* Medicare beneficiaries, Congress specifically addressed the situation of the elderly poor who could not afford the Part B enrollment premiums or pay the cost-sharing amounts.

Thus, from inception in 1965, (i) the Medicare Act permitted states to enroll the poorest of the Medicare beneficiaries – those also eligible for Medicaid – in the Part B program by entering into a "buy-in" agreement with the Secretary and paying the premiums on their behalf, and (ii) the Medicaid Act expressly required that state Medicaid programs assume crossovers' obligation to pay *all* Medicare deductibles and coinsurance amounts except that the states could elect to have a portion thereof paid by the individual on a basis reasonably related to his means. 42 U.S.C. §1396a(a)(15) [repealed] ("(a)(15)"). For services furnished to dual eligibles, the Medicaid Act (42 U.S.C. §1396b(b)(1)) and the Secretary's Regulations (42 C.F.R. §431.625(d)(3)) also provide that payment is to be made pursuant to the *Medicare* reasonable costs and charges rather than pursuant to the rates set under each state's Medicaid program.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, 100 Stat. 1874, 2053-54) expanded this protection for the elderly poor by creating QMBs as a sub-category of Medicare beneficiaries whose incomes and resources were below federal poverty levels, but who were not poor enough to qualify for Medicaid. States were given the option to pay cost-sharing for this new QMB group under the states' Medicaid programs (thereby qualifying for federal matching funds). P.L. 99-509, §9403(a), 100 Stat. 1874, 2053, adding subparagraph (E) to 42 U.S.C. §1396a(a)(10).

The Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, 102 Stat. 683, made two changes concerning QMBs and cost-sharing. First, Congress made it mandatory that state Medicaid programs pay for QMBs' cost-sharing liability. P.L. 100-360, §301(a)(1), 102 Stat. 683, 748 (amending §1396a(a)(10)(E) to delete

the phrase "at the option of a state"). Second, the definition of QMB was broadened to include all Medicare-eligible individuals with incomes below federal poverty levels, whether or not those individuals were also eligible for Medicaid. *See* §8434(a) of the Technical and Miscellaneous Revenue Act of 1988, P.L. 100-647, 102 Stat. 3342, 3805. Thus, although the crossover provision — §1396a(a)(15) — was repealed effective July 1, 1989[2], the obligation of states to pay Medicare cost-sharing in full was continued and made uniform for crossovers and other QMBs through §1396a(a)(10)(E) ("(a)(10)(E)"), discussed below (pp. 9-12 *infra*).[3]

The New York Regulation

In accordance with these requirements, until January 1, 1987, New York paid the full cost-sharing amounts on behalf of crossover beneficiaries. Effective January 1, 1987, the New York State Department of Social Services amended its Regulation 18 N.Y.C.R.R. §360.10 to reduce or eliminate Medicaid payments of cost-sharing amounts for Medicare Part B services.[4] As it relates to this action, the State Regulation permits payment by the New York Medicaid program of QMBs' Medicare Part B cost-sharing obligations only to the extent that the amount paid by the State, plus the 80% Medicare payment of the reasonable cost or charge, does not exceed the level of reimbursement established by the Medicaid fee schedule. For most Part B

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2. *See* P.L. 100-360, §301(e)(2)(C), 102 Stat. 683, 749, as amended by §608(d)(14)(I) of the Family Support Act of 1988, P.L. 100-485, 102 Stat. 2343, 2416.

3. The QMB coverage provisions were initially made optional, rather than mandatory, because "the Committee recognizes that the fiscal constraints facing many states may preclude" more comprehensive coverage. H.R. Rep. No. 727, 99th Cong., 2d Sess., *reprinted in* 1986 U.S. Code Cong. & Ad. News 3607, 3696. The cost-sharing option was made mandatory two years later, notwithstanding these fiscal constraints.

4. Effective March 1, 1989, Section 360.10 was amended without substantive change and recodified as 18 N.Y.C.R.R. §360-7.7. The payment limitation therein was extended to apply to QMBs effective March 21, 1990. N.Y. St. Reg., April 11, 1990, p. 47. Sections 360.10 and 360-7.7 are referred to herein as the "New York Regulation" or "State Regulation."

services, the 80% Medicare payment exceeds the corresponding Medicaid rate for the service. Thus, in most cases the State now pays no part of the Part B cost-sharing amounts.

The Decision Below

The Court of Appeals for the Second Circuit held (Pet. App. 1a-20a) that the New York Regulation violated (i) the Medicaid Act requirement that states pay the full cost-sharing amounts on behalf of crossovers and other QMBs and (ii) the Medicare Act provisions entitling providers to full payment of their reasonable costs and charges for all services, including Part B services, provided to all Medicare beneficiaries, including crossovers and other QMBs. Because it found the statutes to be unambiguous and complete on the specific issue presented, it refused to defer to the Secretary's contrary position. (Pet. App. 9a, 16a-20a.)

All of the active judges of the Second Circuit considered and rejected a petition for rehearing and suggestion for rehearing *en banc*, which set forth all of the arguments here presented. No judge voted in favor of the petition. (Pet. App. 49a.)

REASONS FOR DENYING THE WRIT

This case presents none of the requisite "special and important reasons" (Sup. Ct. Rule 10) for granting a Petition for Certiorari. There is no conflict among the Courts of Appeals or with a state court of last resort; there has been no "depart[ure] from the usual course of judicial proceedings"; no federal question has been decided in a way that conflicts with decisions of this Court; and no question of federal law is presently at stake "that should be settled by this Court." *Id.* Moreover, the Secretary, whose approval of the New York Regulation was invalidated by the Second Circuit, did not seek Certiorari and did not submit a brief in support of the State's Petition, as permitted by Supreme Court Rule 12.4.

In the absence of any recognized basis to support the Petition for Certiorari, Petitioner mischaracterizes the Court of Appeals decision and the applicable provisions of the Medicare and Medicaid Acts so as to create the illusion of a "significant and

unresolved issue of statutory and regulatory interpretation" (Pet. 8) – some "gap" to be filled in by administrative interpretation. Thus the argument (Pet. 9) that review of the decision "will provide this Court with the opportunity to further define the *Chevron* standard." (*See Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837 (1984).)

Supreme Court Rule 15.1 requires us to address misstatements of fact or law set forth in the Petition. There are several. Most significantly, the Petition fails to cite, quote or address the central Medicaid Act provision that conclusively establishes the states' obligations to pay Medicare cost-sharing in full for crossovers and other QMBs.

The Medicare cost-sharing that Section 1396a(a)(10)(E) requires the states to pay on behalf of QMBs is defined (in 42 U.S.C. §1396d(p)(3)) as including *all* Medicare Part B premiums, coinsurance, and deductibles. Cost-sharing is specifically defined ((p)(3)(D)) (Appendix A-1) to include

> "the difference between the amount that is paid under section 1395*l*(a) of this title [*i.e.*, 80% of the reasonable costs and charges for covered Part B services] and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent.' "

The statute thus specifies payment of the "difference between 80% and 100%" and there is no room to defer to the Secretary's interpretation: the "difference between 80% and a state's Medicaid rate."

As shown below, there is no *Chevron* issue to be addressed. The Medicare and Medicaid Acts may be complicated (Pet. 8), but as the Court of Appeals determined, "complexity is not the same as ambiguity." (Pet. App. 19a.) The Court correctly noted that the statute is neither ambiguous nor silent as to the question whether states must pay QMBs' Medicare Part B cost-sharing in full (Pet. App. 17a). Petitioner's attempt to create ambiguity by mischaracterizing the Act and the decision below must fail.

A. Ambiguity, Deference And The *Chevron* Standard

The deference that *Chevron* commands can only be accorded when there is a need "'to fill any gap left, implicitly or explicitly, by Congress.'" 467 U.S. at 843, quoting *Morton v. Ruiz*, 415 U.S. 199, 231 (1974). Petitioner disingenuously attempts to create such a gap by stating that the Court of Appeals "relied principally upon its interpretation of section 1395cc(a)(2)(A) of the *Medicare* Act and legislative history applicable primarily to Medicare Part A" in concluding that states were required to pay Medicare Part B cost-sharing in full on behalf of QMBs (Pet. 8, emphasis in original). In fact, as shown below, the Court of Appeals relied not only on §1395cc(a)(2)(A), but on other provisions of the *Medicaid* Act — provisions that Petitioner virtually ignores — that clearly and unambiguously require states to pay QMBs' Medicare Part B cost-sharing in full.

1. The Statutory Requirement of Payment in Full

Section 1395cc(a)(2)(A) states that providers are entitled to charge the 20% coinsurance for covered services furnished to Medicare beneficiaries (*see* Pet. App. 54a).[5] Because that provision does not specify "Medicare beneficiaries, *including dual eligibles and other QMBs*" Petitioner argues that the provision is ambiguous, thus enabling him to read into it a *sub silentio* exception for dual eligibles and other QMBs. With equal fervor it could be asserted that the statute is ambiguous because it does not expressly state "all Medicare beneficiaries, including New York residents."

There is, however, no statutory gap or conflict with respect to these beneficiaries or services. The Medicare Act (including §1395cc(a)(2)(A)) requires, by its terms, payment of full reasonable costs and charges for *all* services to *all* Medicare patients. These provisions are absolute and exceptions thereto are nowhere articulated. There is no basis for engrafting the exceptions urged

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5. Other provisions of the Medicare Act and Regulations establish providers' right to receive full payment of their reasonable costs or charges. 42 U.S.C. §1395*l*; 42 C.F.R. §§405.501, 410.150, 410.152.

by the Petitioner: "all Medicare patients except crossovers/QMBs" or "all services except Part B services for crossovers/QMBs."

To the contrary, Congress specifically intended the reasonable costs and charges provisions to apply to crossover/QMB services. At the *very same time* that Congress created Medicare in 1965, it provided in the parallel Medicaid Act ((a)(15)) that states were obliged to pay the Medicare coinsurance amounts for crossovers. And the states were so obliged for the *very reason* that the elderly poor could not pay themselves and Congress wanted them to have full and equal access to all Medicare services. That is why the Medicare reasonable cost/charge provisions contain no express exception: none was intended. The states would pay on behalf of crossovers – and later for QMBs under (a)(10)(E) – and full reasonable costs/charges would thereby result.[6]

Wholly apart from the Medicare Act requirements and wholly apart from whether these patients can be characterized as "primarily Medicaid" or "primarily Medicare," the specific requirements of (a)(15), (a)(10)(E) and 1396d(p)(3) control. *These* provisions are surely not "silent or ambiguous with respect to the specific issue." There is thus no *Chevron* issue to be addressed.

Finally, Petitioner (again ignoring (a)(15), (a)(10)(E) and 1396d(p)(3)) cites §1396a(n) as the "section of the Medicaid Act [that] deals specifically with payment for services to QMBs . . . ." (Pet. 9.) But as the Court of Appeals found, this provision, which stipulates that states "may" pay more than the Medicaid rate for QMBs' cost-sharing, cannot be stretched into

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6. Petitioner's statement (Pet. 8) that there is an "absence of express language" elsewhere in the *Medicare* Act supporting the conclusion that states must pay QMBs' cost-sharing in full is both literally true and quite misleading: Sections (a)(15), (a)(10)(E) and 1396d(p)(3) of the *Medicaid* Act clearly provide for state payment in full of QMBs' Medicare cost-sharing. (The text of Section (a)(15) can be found at Pet. App. 55a; Sections (a)(10)(E) and 1396d(p)(3) are set forth in the Appendix to this brief, p. A-1)

an *implicit* option to pay less than the full cost-sharing *expressly* required by (a)(10)(E) and §1396d(p)(3).[7]

2. Payment in Full for Part B Services

Petitioner concedes (Pet. 9-10) and the Dissent acknowledged (Pet. App. 27a), that Congress intended Part A cost-sharing to be paid by the states for crossovers/QMBs, but not Part B. The recognition that states must pay Part A cost-sharing in full necessarily leads to the conclusion that Part B cost-sharing must also be paid in full: the Medicaid Act makes no distinction in terms of its compulsion. Significantly, Petitioner can point to no provision in the statutes that specifies such a Part B exception to the states' obligation to pay Medicare cost-sharing.

Initially, there were, indeed, different Part A/Part B requirements for state payment of cost-sharing. But the different requirement chosen by Congress was not that suggested by Petitioner and, in any event, was *obliterated in 1968*, when the states' obligations were made uniform for both Part A and Part B.

As originally enacted in 1965, (a)(15) required the states to pay Part A cost-sharing in full, but where "all" of the Part B cost-sharing was not paid by the state, the amount paid had to be determined in accordance with the beneficiaries' means. *See* Social Security Amendments of 1965, Pub. L. 89-97, §121(a), 70 Stat. 286. Thus, some small portion of the state's obligation could be imposed on the beneficiary for Part B, but not Part A

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7. Section 1396a(n) simply makes clear that the general Medicaid provisions that in effect provide that states "may not" pay, and providers "may not" receive, more than the Medicaid rate for treating Medicaid patients cannot be read as limiting a State's cost-sharing obligations in the case of QMBs. Indeed, Petitioner here suggests (Pet. 3, 10-11) that those very Medicaid provisions – §§1396a(a)(25), 1396h(d) and 42 C.F.R. §447.15 – still limit the State's obligation to its Medicaid rate, notwithstanding that §1396a(n) provides that those limitations may be exceeded for crossovers and other QMBs. The State "may" pay more by virtue of §1396a(n) and *must* pay more – the difference between 80 percent and 100 percent – by virtue of (a)(10)(E) and §1396d(p)(3).

services. That was the distinction drawn by Congress and the only distinction.[8]

Congress eliminated this difference in 1968 by also permitting some portion of the Part A coinsurance obligation to be imposed on the beneficiaries. *See* Social Security Amendments of 1967, Pub. L. 90-248, §235(a)(3), 81 Stat. 821. The states' obligations were thereafter identical for both Part A and Part B coinsurance amounts. There is no basis to conclude that in amending the statute, Congress intended to change from explicitly commanding states to pay dual eligibles' Part A cost-sharing in 1965 to permitting the states to pay nothing at all in 1968. Rather, as (a)(15) expressly provides, the states could limit their obligation only to the extent that the beneficiaries could afford to assume a portion of the costs – for both Part A and Part B services.

Nor is any Part A/Part B distinction found in the QMB legislation. To the contrary, those provisions expressly address and require the states to pay Part B cost-sharing on behalf of QMBs. As noted, Section (a)(10)(E) requires states to make "medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3)," which definition includes all Part A *and* Part B cost-sharing amounts: specifically enumerated are Part A premiums, *Part B* premiums, Part A and *Part B* Medicare coinsurance, Part A deductibles, *Part B* deductibles and, most significantly, "the difference between 80 percent and 100 percent."

There is, accordingly, no basis to distinguish between states' cost-sharing liability for Part A and Part B services. If, as

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8. Thus, because under the original (a)(15) states could either pay Part B cost-sharing in full or impose a portion of the cost-sharing liability on the dual eligible according to his means, the 1965 Senate Report stated that a state plan "*may* provide for the payment in full of any [cost-sharing]" or that it could require the individual "to share in the cost." S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2020 (emphasis added). There is no ambiguity here: payment of the full cost is required for both Part A and Part B services, and as to the latter, some share of the liability can be imposed on the individual. Ambiguity can only be created if attention is selectively focused on isolated words (*e.g.*, "may") taken out of context (*see* Pet. 10).

Petitioner acknowledges, it would be arbitrary to differentiate between crossovers/QMBs and other Medicare patients for Part A, and Congress has explicitly commanded full payment for Part A, the same conclusion necessarily follows for Part B since at least 1968 when all differences were removed.

Congress was surely not "silent" on the "specific issue" – the *Chevron* standard for according deference – of Part B coinsurance for crossovers/QMBs. Nor was it ambiguous: the states must pay all Medicare cost-sharing and specifically the difference between "80 percent" and "100 percent" of the Part B reasonable costs/charges. There is no room for doubt or basis to defer to the Secretary's contrary interpretation (the difference between "80 percent and the Medicaid rate").

As *Chevron* instructs (467 U.S. at 842-43), "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Here, Congress has not been silent on the specific issue of Part B coinsurance. It has spoken and expressed its intent unambiguously in the statutory words used. New York *must* pay the difference between "80 percent" and "100 percent" and, as *Chevron* mandates, "that is the end of the matter." The Court below correctly applied the *Chevron* deference standard and no occasion is presented for this Court "to further define" that standard.

Petitioner nevertheless repeatedly suggests (Pet. 3, 10, 11) that treatment of crossovers as Medicaid patients is appropriate because they "are only enrolled in the Medicare program by the states by virtue of their status as Medicaid recipients" (Pet. 10), and that New York can simply terminate enrollment in Part B or stop paying premiums. But the statute makes enrollment and payment mandatory. Petitioner's characterization of crossovers as "primarily Medicaid patients" is simply an invention without substance or basis, and does not take into account the many QMBs who are not even eligible for Medicaid.[9]

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9. A related argument cannot be taken seriously: Petitioner argues that the Court of Appeals decision provides a "windfall" for treating dual eligibles and a "two-tiered, unequal Medicaid reimbursement scheme, one for Medicaid-eligible only, and another higher level for Medicaid-eligible who

The other arguments asserted in support of the Petition (that the Court of Appeals decision has "national significance," contains a "comprehensive analysis" of the legal positions, and has "immediate and drastic fiscal consequences for New York") take less time to address.

B. "National Significance"

Petitioner argues (Pet. 7, 11) that because the Secretary has approved payment limitations in some 30 other states that are said to be "similar to" the invalidated New York Regulation, the decision has "national significance" and should be reviewed by the Supreme Court. But the same could be said of virtually every court decision involving the Medicare and Medicaid programs, both of which are national in scope. Any decision invalidating the Secretary's program policies could be said to have "national significance," but that alone should not be a basis for granting certiorari, particularly where, as here, the Secretary — who administers the programs at the national level — has not petitioned this Court for a Writ of Certiorari and has not filed a brief in support of the State's Petition.

C. "Comprehensive Analysis of the Issues"

Petitioner's argument (Pet. 8) that the Second Circuit decision contains a "comprehensive analysis" of the legal issues presented, in fact, supports the position that the Petition should be denied. The decision is thorough, comprehensive, and above all, correct, and there is thus no error for this Court to redress.

Although Petitioner refers to "similar" payment limitations in other states, there is nothing in the record concerning such payment limitations or the extent to which they might be similar to the New York limitation at issue here. They may be broader (or narrower) than New York's, and more appropriate for

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also happen to be Medicare eligible." (Pet. 11.) But the point is that Congress determined to avoid two classes of *Medicare* beneficiaries based on wealth, as the Court of Appeals found: "Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled" by assuring providers of reasonable cost/charge reimbursement — "even when that provider is treating a Medicare patient who happens also to be poor." (Pet. App. 11a; 13a.) Moreover, what do Medicaid rates have to do with those QMBs who are not even eligible for Medicaid?

Supreme Court review (if at all) after the lower courts have considered and ruled on such limitations.

For example, the New York Regulation applies only to Part B cost-sharing. The Dissent below and Petitioner here agree that the New York payment limitation, if applied to Part A services, would be unlawful (Pet. 9-10; Pet. App. 27a), but, on information and belief, some states, at the urging of the Secretary, have limited payment of cost-sharing for Part A as well as Part B services.

It should further be noted that the Secretary intends to publish regulations implementing the (a)(10)(E) requirement that states pay QMBs' Medicare cost-sharing, but has not done so to date. Those regulations, when published, would "require states to include in their State plans payment of Medicare cost-sharing for low income Medicare beneficiaries" and would "propose requirements and options for payment amounts and limitations . . . ." 57 Fed. Reg. 16759, 16765 (April 27, 1992). Thus, the Secretary has under active consideration issues at the very heart of this case.

The Second Circuit decision was comprehensive (and correct) as to the issues before it, but important related questions remain to be considered and, perhaps, litigated. By waiting for future cases and the adoption of federal regulations, the Court might have the benefit of a more thorough delineation of the issues.

D. "Drastic and Immediate Fiscal Consequences"

Petitioner's complaint (Pet. 8) of "immediate and drastic" fiscal consequences of the Court of Appeals decision is disingenuous. Petitioner was entitled, pursuant to Fed. R. App. P. 41(b), to move to stay the issuance of the mandate in the Court of Appeals pending a petition for certiorari, and chose not to do so. Moreover, Petitioner waited until the last day to file his Petition. Surely if the fiscal consequences were as immediate and drastic as Petitioner asserts, he would have sought to stay the mandate and would have promptly sought review in this Court. Petitioner should not be allowed to forego available remedies and then use the consequences thereof as a basis for seeking Certiorari.

Moreover, while the decision may cost the State a significant amount of money, these were amounts that until 1987 were paid in full by the State. From the inception of the Medicare and Medicaid programs in 1965 until January 1, 1987, *New York paid in full the Medicare cost-sharing amounts here at issue.* The decision thus does nothing more than restore the *status quo ante* by reinstating the State's pre-1987 policy.

In any event, neither budget constraints, nor the Medicaid Act's general statement of legislative purpose to provide medical assistance "as far as practicable" under state conditions (Pet. 10), has ever been held to excuse a state's compliance with mandatory federal requirements.[10] Contrary to Petitioner's assertion (Pet. 10), the Medicaid Act provisions that require state payment of Medicare cost-sharing are in no way related to a state's authority to set Medicaid rates for covered Medicaid services. No latitude whatsoever is granted with respect to the former.

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10. *E.g.*, *West Virginia Univ. Hosp. v. Casey*, 885 F.2d 11, 23-24 (3d Cir. 1989) ("budgetary constraints . . . [cannot] excuse a failure to conform to" federal standards), *aff'd*, 496 U.S. 936 (1990); *AMISUB (PSL), Inc. v. Colorado Dept. of Social Services*, 879 F.2d 789, 800 (10th Cir. 1989) ("budgetary constraints cannot excuse noncompliance with federal Medicaid law"), *cert. denied*, 496 U.S. 935 (1990).

CONCLUSION

For all of the foregoing reasons, Respondents New York City Health and Hospitals Corporation, Medical Society of the State of New York, Finkel and Bleski respectfully submit that the Petition for a Writ of Certiorari should be denied.

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Respectfully submitted,

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